STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155304	A. BUILDING 01 B. WING	07/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF NEW CASTLE, THE	1000 N 16TH ST NEW CASTLE, IN47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/25/11 Facility Number: 000201 Provider Number: 155304 AIM Number: 100267910 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, The Waters of New Castle was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The Waters of New Castle was located on the third floor of a four story sprinklered hospital determined to be of Type I (332) construction with a basement. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility	K0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8/24/2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	has a capacity of 66 and had a census of 50 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/29/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 75 rooms were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance	K0025	K 025It is the intent of this facility to ensure smoke barriers in rooms are constructed to provide at least a one half hour fire resistance rating.1. Corrective action for affected residents: a. All wall penetrations in the elevator landing were filled with Fire Barrier Sealant by the Maintenance Supervisor.2. Other Residents with the potential to be affected: A. Maintenance Supervisor completed audit for all fire/smoke walls to ensure walls are free of opened penetrations. No other areas were identified.3.	08/24/2011

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	of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 36 residents who reside on the 300 Hall with resident rooms numbering room 300 to room 356. Findings include: Based on observation with the maintenance supervisor on 07/25/11 at 10:50 a.m., the elevator landing room had four, two inch to four inch penetrations in the south wall and two, three inch penetrations in the ceiling from electrical conduit and water piping filled with expandable foam. Based on an interview with the maintenance supervisor on 07/25/11 at 10:55 a.m., the expandable foam is not a fire rated material. 3.1-19(b)		Measures to prevent reoccurence: A. Maintenance Supervisor/designee will complete monthly audits to ensure fire/smoke walls are free from open holes/cracks as part of the preventative maintenance program.4. Monitoring of corrective action to ensure the practice will not recur: A. Administrator/designee will review the audit results in the monthly safety meeting and in the facility quarterly QA meeting.5. Date of compliance: A. 8/24/2011	
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the	K0027	K 027It is the intent of this facility	08/24/2011

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	facility failed to ensure 3 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect all residents in the facility. Findings include: Based on observations on 07/25/11 during a tour of the facility from 9:30 a.m. to 2:10 p.m. with the maintenance supervisor, the set of smoke barrier doors by resident room 304, the set of smoke barrier doors by resident room 334, and the set of smoke barrier doors by resident room 344 each had a one inch gap where the pair of doors met. This was verified by the maintenance supervisor at the time of observations. 3.1-19(b)		to ensure smoke barrier doors will restrict the movement of smoke for at least 20 minutes.1. Corrective action for affected residents: a. Henry County Hospital Maintenance staff made adjustments to smoke barrier doors by resident rooms 304, 334, and 344 to ensure complete door closure. 2. Other residents with the potential to be affected: a. Maintenance Supervisor completed audit of all smoke barrier doors to ensure adequate closure. No other areas of concern were identified.3. Measures to prevent reoccurrence: a. Maintenance Supervisor/designee will complete monthly audits as part of the preventative maintenance program to ensure smoke barrier doors close completely.4. Monitoring of corrective action to ensure the practice will not recur:a. The Administrator/Designee will review the audit results in the monthly safety meeting and again in the facility quarterly QA meeting.5. Date of Compliance: a. 8/24/2011	

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to ensure the corridor door to 2 of 5 hazardous areas, such as a laundry room and a combustible storage room, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 36 residents who reside on the 300 Hall with resident rooms numbering room 300 to room 356. Findings include: Based on observations on 07/25/11 during a tour of the facility from 9:30 a.m. to 2:10 p.m. with the maintenance supervisor, the self closing devices on the two doors to the laundry which measured three hundred twelve square feet in size each failed to close and latch the doors leaving a one inch gap, and the door to the clean utility room which measured three hundred sixteen square feet and had six	K0029	It is the intent of this facility to ensure the corridor doors to hazardous areas are provided with self closing devices which cause the doors to automatically close and latch into the door frame.It is the intent of this facility to ensure soiled linen receptacles of more than 32 gallons are located in a room with smoke resistant walls equiped with a self closing door.1. Corrective action for affected residents: a. Henry County Hospital Maintenance staff installed self closing devices to 2 doors in the laundry room to ensure closure and latching of doors into the door frames. HCH maintenance staff made adjustments to the self closing device attached to the clean utility room door to ensure complete closure and latching of door into the door frame. b. Maintenance staff installed inserts in the soiled linen containers used in the facility corridors limiting the internal capacity to less than or eaqual to 32 gallons.2. Other Residents with the potential to be	08/24/2011

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	shelves of combustible clean linens failed to close and latch leaving a one inch gap between the door and frame. This was verified by the maintenance supervisor at the time of observations. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure hazardous areas in 2 of 4 smoke compartments such as storage for soiled linen receptacles of more than 32 gallons within a 64 square foot area were located in a room with smoke resistant walls equipped with a self closing door. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice affects all residents in the facility. Findings include: Based on observations on 07/25/11 during a tour of the facility from 9:30 a.m. to 2:10 p.m. with the maintenance supervisor, the 300 Hall corridor by resident room 348, the 300 Hall corridor		affected: a. Maintenance supervisor completed an audit for all corridor doors to hazardous areas to ensure placement of self closing devices causing door closure and latching into door frames. No areas of concern noted. b. Maintenance supervisor completed an audit for all soiled linen receptacles to ensure less than or equal to 32 gallons capacity limit is met. 3. Measures to prevent reoccurrence: a. Maintenance supervisor/designee will do monthly audit as part of the preventative maintenance program of all corridor doors to hazardous areas to ensure door closure and latching into door frame. b. Maintenance supervisor/designee will do monthly audit as part of the preventative maintenance program of all soiled linen barrels located in facility corridors to ensure placement of inserts.4. Monitoring of corrective action to ensure the practive will not recur: a. Administrator/designee will review the audit results in the monthly safety meeting and quarterly in the facility QA meeting.5. Date of Compliance: a. 8/24/2011	

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	by resident room 370, and the 300 Hall corridor by resident room 378 each had a soiled linen container with two, twenty four gallon soiled linen containers totaling forty eight gallons each stored in the corridor. Based on observation of the corridors on 07/25/11 at 9:45 a.m., the three soiled linen containers were stored in the corridor upon arrival at the facility and were still stored in the corridor on 07/25/11 at 1:50 p.m. Based on an interview with the maintenance supervisor on 07/25/11 at 2:00 p.m., the three forty eight gallon soiled linen containers are stored in the corridor permanently and just moved during the day while nursing staff are using them. The receptacle size was verified on the bottom of each receptacle and acknowledged by the maintenance supervisor at the time of observations. 3.1-19(b)			
K0038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit access was arranged so 2 of 3 exits were readily accessible at all times. LSC 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards,	K0038	K 038It is the intent of this facility to ensure exit access is readily accessible at all times.1. corrective action for affected residents: a. Facility request annual life safety code waiver regarding exit #3. See attachment State form 54147. b. Henry County Hospital maintenance to install a concrete	08/24/2011

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	courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Where discharging exits into yards, across lawns, or on similar surfaces, in addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect all residents in the facility. Findings include: Based on observations with the maintenance supervisor on 07/25/11 during a tour of the facility from 9:30 a.m. to 2:10 p.m., the stairwell three exit discharged onto a six foot by twenty foot concrete slab and terminated onto a grassy surface, and the stairwell one exit discharged onto a six foot by ten		slab replacing the grassy surface for exit #1.2. Other residents with the potential to be affected: a. No residents were affected.3. Measures to prevent reoccurrence: a. Maintenance supervisor to audit condition of exit #1 to ensure accessiblity as part of the facility preventative maintenance program.4. Monitoring of corrective action to ensure the practice will not recur: a. Administrator/designee will review the audits in the monthly safety meeting and in the quartely QA meeting.5. Date of compliance: a. 8/24/2011	

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	foot concrete slab and terminated onto a grassy surface. Based on an interview with the maintenance supervisor and hospital's maintenance director on 07/25/11 at 12:40 p.m., the exit three and exit one grassy surfaces were not being kept clear and level during periods of snow and rain and the grassy surfaces were saturated with water during a few months of the year, preventing the grassy surfaces being used as an evacuation route. 3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were held on 1 of 3 shifts over the past year. This deficient practice affects all resident in the facility. Findings include:	K0050	It is the intent of this facility to ensure fire drills are held quarterly on each shift.1. Corrective action for affected residents: a. Inservice provided to Safety/Security Director of Henry County Hospital regarding requirement to hold fire drills quarterly for all shifts. Facility	08/24/2011

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	Based on review of the 2011 Quarterly Fire Drill Summary Report with the hospital's Safety Director on 07/25/11 at 1:15 p.m., there was no record of a fire drill conducted on the second shift for the first quarter of the year 2011. Furthermore, the previous second shift fire drill before the first quarter of 2011 was conducted on 11/15/10 at 6:23 p.m. and the fire drill for the second quarter second shift 2011 was conducted on 06/30/11 at 4:40 p.m., which was a period exceeding the three month requirement. The lack of a fire drill record for second shift during the first quarter of the year 2011 was verified by the hospital's Safety Director at the time of record review. 3.1-19(b)		performs own fire drill as secondary fire drill awareness training.2. Other Residents with the potential to be affected: a. no residents were affected3. Measures to prevent reoccurrence; a. Administrator/designee will review schedule of quarterly fire drills for HCH ensuring all shifts are included timely.4. Monitoring of corrective action to ensure the practice will not recur: a. Administrator/designee will review the Fire Drill Summary report for HCH in the monthly safety meeting and quarterly in the facility QA meeting and in HCH quarterly QA safety meeting.5. Date of Compliance: a. 8/24/2011	
K0075 SS=E	Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure soiled linen containers in 2 of 4 corridors did not exceed 32 gallons. This deficient practice could affect all resident in the facility. Findings include:	K0075	K 075It is the intent of this facility to ensure soiled linen containers in corridors do not exceed 32 gallons.1. Corrective action for affected residents: a. Maintenance installed inserts to	08/24/2011

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	Based on observations on 07/25/11 during a tour of the facility from 9:30 a.m. to 2:10 p.m. with the maintenance supervisor, the 300 Hall corridor by resident room 348, the 300 Hall corridor by resident room 370, and the 300 Hall corridor by resident room 378 each had a soiled linen container with two, twenty four gallon soiled linen containers totaling forty eight gallons each stored in the corridor. Based on observation of the corridors on 07/25/11 at 9:45 a.m., the three soiled linen containers were stored in the corridor upon arrival at the facility and were still stored in the corridor on 07/25/11 at 1:50 p.m. Based on an interview with the maintenance supervisor on 07/25/11 at 2:00 p.m., the three forty eight gallon soiled linen containers are stored in the corridor permanently and just moved during the day while nursing staff are using them. The receptacle size was verified on the bottom of each receptacle and acknowledged by the maintenance supervisor at the time of observations. 3.1-19(b)		the soiled linen containers limiting the internal capacity to less than or eaqual to 32 gallons.2. Other Residents with the potential to be affected: a. Maintenance supervisor completed an audit of all soiled linen containers to ensure less than or equal to 32 gallon capacity limit is met.3. Measures to prevent reoccurrence: a. Maintenance supervisor/designee will do monthly audit of all soiled linen recepticles to ensure placement of inserts.4. Monitoring of corrective action to ensure the practice will not recure: a. Administrator/designee will review the audit results in the monthly safety meeting and quarterly in the facility QA meeting.5. Date of compliance: a. 8/24/2011	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to provide 1 of 1 emergency generator locations with emergency	K0144	K 144It is the intent of this facility to provide emergency generator locations with emergency lighting.1. Corrective action for	08/24/2011

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	lighting. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice affects all residents in the facility. Findings include: Based on observation with the maintenance supervisor and hospital's maintenance director on 07/25/11 at 12:45 p.m., the Detroit diesel emergency generator which supplied emergency power to the third floor of the hospital was housed in a metal building outside of the stairwell three exit. The generator building lacked battery powered emergency lighting. This was verified by the maintenance supervisor and hospital's maintenance director at the time of observation. 3.1-19(b)		affected residents: a. HCH maintenance installed emergency lighting to emergency generator location.2. Other Residents with the potential to be affected: a. No residents were affected.3. Measures to prevent reoccurrence: a. HCH maintenance to audit and test emergency lighting for emergency generator location to meet set standards.4. Monitoring of corrective action to ensure the practice will not recur: a. Administrator/designee will review the audits in the monthly safety meeting and quarterly in the facility QA meeting.5. Date of Compliance: a. 8/24/2011	